

**DC-STEP: Healthy Infants and Mothers Program
Nicotine Monitor Placement/Safety
Observation Determination
BASELINE**

SUBJECT ID LABEL

TODAY'S DATE: | | - | | - | | | |
mm dd yyyy

1. Do you currently... Own your own home 1
Rent your home 2
Live with someone else who rents the home 3
Live with someone else who owns the home 4
2. Including yourself, how many people currently live in your household, either on a part time or full time basis? | |
3. For each person living in your household, I need to know their gender and age, and whether or not they currently smoke cigarette. Let's start with you. (RECORD PARTICIPANT IN FIRST ROW AND COMPLETE COLUMNS C-F FOR HER.) Now let's list other members of the household starting with the oldest. . .

R O W #	Column A What is this person's name?	Column B What is this person's relationship to you? (USE CODES BELOW)	Column C How old is this person?	Column D Is this person male or female?	Column E Does this person smoke cigarettes inside the home? Consider a cigar and a pipe bowl of tobacco the same as smoking tobacco from a cigarette.
1		0 1	yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
2			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
3			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
4			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
5			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
6			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
7			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
8			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
9			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
10			yrs mos	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

RELATIONSHIP CODES:	01=Participant 02=Husband 03=Partner	04=Parent 05=Parent-in-law 06=Other adult relative	07=Other adult in-law 08=Unrelated adult 09=Child	10=Step child 11=Unrelated child
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4. Who is the head of household, that is, the person(s) in whose name the home is owned or rented?

INDICATE ROW # FROM HH TABLE: |_|_|| |_|_|| |_|_|| |_|_|| |_|_||

OWNER OR RENTER DOES NOT LIVE IN HOUSEHOLD -7 → SPECIFY RELATIONSHIP TO MOTHER AND CODE

4a. _____ CODE: |_|_|_|

LIST ALL ROOMS IDENTIFIED ON THE MAP WITH THEIR ASSIGNED MAP CODE # AND ASSOCIATED ROOM CODE #

ROOM	MAP CODE #	ROOM CODE # →	ROOM CODE # KEY	
			Baby's room	01
			Mother's bedroom	02
			Other bedroom (SPECIFY)	03
			Living room/family room	04
			Dining room	05
			Kitchen	06
			Bathroom	07
			Other (SPECIFY)	08

REVIEW MAP OF HOME WITH MOTHER. EXPLAIN WHICH AREAS, IF ANY, ARE COMBINED TO BE ONE ROOM FOR PURPOSES OF UPCOMING QUESTIONS.

MAPCODE #

5. In which room do you spend most of your time during the day?|_|_|_|
6. In which room do you spend most of your time during the evening or at night, when you are not sleeping?|_|_|_|
- †7. In which room do other members of your household spend most of their time during the day?.....|_|_|_|
8. In which room do other members of your household spend most of their time during the evening or night, when they are not sleeping?|_|_|_|
- †9. In which room would you say that most cigarette smoking occurs?.....|_|_|_|
- †10. In which room would you say that the 2nd most cigarette smoking occurs?.....|_|_|_|
11. In what other rooms of your house does cigarette smoking typically occur?.....|_|_|_|..|_|_|_|..|_|_|_|
- μ†12. After you give birth, where will your baby spend most of his or her time during the day?|_|_|_|
- μ13. After you give birth, where will your baby usually take his or her naps?.....|_|_|_|
- μ14. After you give birth, where will your baby usually sleep at night?|_|_|_|
- μ15. After you give birth, where will you clean, bathe, or give your baby a bath?|_|_|_|
16. What other rooms in your house might your baby spend time?|_|_|_|..|_|_|_|..|_|_|_|
- †17. Of all the rooms where your baby will spend time, in which room of your house will he or she be most often exposed to cigarette smoking?|_|_|_|

†Determines placement of nicotine monitors

μ Determines rooms to conduct safety observation.

DETERMINE PLACEMENT OF NICOTINE MONITORS AND COMPLETE THE FOLLOWING GRID. THEN COMPLETE SECTIONS A AND C OF THE NICOTINE MONITOR DROP-OFF/PICK UP FORM.

	Primary Monitor	Duplicate Monitor	Blank Monitor	Long Term Monitor	Extra Monitor #1	Extra Monitor #2
Map Code #						
Room Code #						